DRAFT

MENTAL HEALTH SERVICES ACT
CAPITAL FACILITIES

Stakeholder Meetings November 14 and 17, 2006

I. Introduction

The Mental Health Services Act (MHSA) provides funding for services and supports that promote wellness, recovery and resiliency for adults and older adults with severe mental illness and for children and youth with serious emotional disorders and their family members. A portion of the MHSA funds have been specifically set aside for capital facilities and technology in fiscal years 2004-2005 through 2007-2008 to enable counties to implement their Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) Plans. In subsequent fiscal years, counties may continue to use a portion of their MHSA CSS funding for capital facilities and information technology.

The purpose of this document is to present up-dated information regarding capital facilities and ideas on how capital funds could be used to meet the goals of the MHSA. This information is a basic summary of prior stakeholder feedback and will serve as the basis for additional input regarding capital facilities expenditures. This document does not include information about how the capital funds will be divided among the counties or what counties must do to receive the capital funds, but is focused on underlying principles and proposals for the most effective uses of these funds.

II. Initial Stakeholder Outreach

At the Department of Mental Health's request, the Corporation for Supportive Housing (CSH) developed a draft guideline for capital facilities by gathering ideas and opinions from clients, their family members, service providers, housing developers and other key stakeholders. CSH and partner organizations conducted focus groups with clients including transition age homeless youth and monolingual individuals. Mental Health Directors from large, medium and small counties including metropolitan, exurban, and remote, rural counties were interviewed. Additional information came from discussions with people from statewide, regional and local groups that represent mental health service providers and organizations that serve clients (including children/youth, transition-aged youth, adults and older adults) and their family members.

The draft guideline for capital facilities was posted on the MHSA Web page dated June 13, 2005. On June 23, 2005, a Capital Facilities work group met and a summary of this meeting may also be found on the Stakeholder meeting section of the MHSA Web page. In addition, a discussion of Frequently Asked Questions related to expenditures of capital facilities funds on housing is posted on the Frequently Asked Questions section of the MHSA Web page.

Housing /Facility Needs Identified

Clients and other key stakeholders have suggested the following uses of MHSA capital funds:

- Acquisition and rehabilitation costs for developing facilities for community-based crisis stabilization ("23 hour") and crisis residential facilities that provide an alternative to hospitalization for clients who experience acute psychiatric crises.
- Crisis stabilization ("23 hour") and crisis residential facilities for children and young people, separate from adult facilities. Short- term (a few days to a few weeks) community-based residential care to avoid hospitalization and allow for a quick return to the family.
- Expanded and/or de-centralized facilities for outpatient mental health clinic services located in areas that are more accessible to clients.
- New mental health clinic capacity that is co-located with community-based primary care clinics to better integrate mental health with other health services, particularly for clients who find care in community clinic settings to be less stigmatizing and more culturally appropriate, and for those who have co-occurring medical and mental health conditions.
- Purchase, construction, and/or renovation costs to create Family Resource Centers that provide one-stop service settings for family members with seriously emotionally disturbed children or youth. Family Resource Centers can provide easy access to services and supports, including services operated by peers and family members and community-based organizations. The one-stop service setting can also make it easier for public and private agencies that are part of the mental health, juvenile justice, child welfare, social service and other systems to work together if staff are placed in this community-based location.
- Community-based residential treatment for youth with co-occurring disorders.
- Community-based residential treatment for adults with co-occurring disorders, including facilities where parents can receive treatment while caring for their children, avoiding out-of-home placements.
- Community-based assessment centers for children and youth, which encourage the participation of family members in the assessment process.
- Crisis or interim housing for youth where the length of stay is not time-limited.
- Facilities for client/peer operated wellness and recovery support centers.
- Renovation and expansion of existing mental health clinic space to relieve crowding and make the facility more welcoming and client-friendly.

- Separate waiting rooms and/or entrances for young people with emotional or behavioral problems who may find it difficult to use a crowded clinic waiting room.
- A range of housing options for clients and their family members.

Client Housing Preferences

In a series of focus groups, clients and family members were asked about their housing preferences. Overall, the information gathered from clients confirms the need for a range of housing options so that clients have real choices about where they live and with whom they live.

- A significant majority would prefer to live alone in their own apartment in a location where voluntary services are available on-site or nearby in the community.
- Most clients are willing to pay more rent to have their own apartment.
- If they had to live with others, clients would prefer to have their own room and live with friends or other un-related adults.
- Some parents expressed a preference for living in a setting with other clients and their family members.
- Other parents raised concern that living with other identified clients could be stigmatizing for children, youth and other family members.
- Some clients prefer to live in housing where all the tenants have made a commitment to being clean and sober and creating a community of mutual support for recovery.
- Other clients said they would not live in a place with rules that prohibited drinking.

III. Principles for the use of MHSA capital funds (proposed)

Based on the initial work and stakeholder input, DMH has revised the principles for the use of capital facilities funds. The revised principles follow:

MHSA funds are to be used to fundamentally transform the public mental health delivery system in California with the goal of a system oriented on wellness, recovery, and resilience. Each county's ideas about how to use capital funds should be viewed alongside the County's Community Services and Supports and Prevention and Early Intervention Plans. The County should clearly show how the planned use of the capital facilities funds would support MHSA outcomes such as:

- Create safe and adequate housing and a reduction in homelessness
- Provide timely access to needed help, including in crisis situations
- Reduce inappropriate institutionalization and incarceration

The MHSA capital funds shall be used to:

- **Produce long-term impacts with lasting benefits for clients and their families,** such as an increase in community-based, less restrictive settings, housing stability and/or savings by reducing ongoing costs including inappropriate incarceration or institutionalization.
- **Increase the number and variety of community-based facilities**, which support integrated service experiences for clients and their family members.
- Support a **full range of community-based living options** that promote client choice and preferences, client independence, and client integration in the larger community.
- **Develop community-based living options** that will be available for the long term such as housing that is dedicated to long term use by clients or leases that guarantee access and affordability for an extended period of time.

Capital facilities can include housing and other buildings that enable mental health clients and their family members to live in the most independent, least restrictive housing possible in their local community and to receive services in community-based settings that support wellness, recovery and resiliency. Capital facilities development and expenditures must be consistent with a county's approved CSS and PEI Plans.

A **"capital facility**" is a permanent building that is used for the delivery of MHSA services or to meet the housing needs of mental health clients and their families. Capital facility funds may be used to acquire, develop or rehabilitate such buildings.

MHSA capital funds can be used:

- To purchase a building for use as clinic, clubhouse, wellness and recovery center
- To purchase a building where vocational, educational and recreational services are provided to clients
- To purchase a house which can provide shared living for clients
- To purchase an apartment building where mental health clients can live independently
- To purchase land where client housing can be built
- To renovate existing housing
- To purchase land where a clinic, clubhouse or other types of building that support the goals of the MHSA can be built

- To make an existing building more accessible to clients and family and compliant with the Americans with Disabilities Act (ADA)
- To make other physical changes and improvements to buildings that will enable them to be used for delivery of MHSA services

Operating Reserves (Under Analysis)

In order to make housing affordable to clients, the Department is also considering the use of MHSA funds to create an operating reserve. An operating reserve is like a bank account. MHSA funds would be reserved to cover the gap between the total amount of rent collected from all the tenants in one housing setting (typically each tenant will pay between 30-50% of his/her income) and the real cost of operating the building. The reserve should be sufficient to ensure operation of the housing for a period of ten to fifteen years. Covered costs include utilities, security, property maintenance and other costs necessary to keep the building safe and secure. An operating reserve "stays" with the building. (Designation of these dollars as Capital Facility or CSS is still under analysis.)

Additional considerations in planning for the use of capital facilities funds:

- Separate facilities may be needed for adults, transition-aged youth and children – even when addressing similar needs for services and supports.
- Facilities that provide opportunities for inter-generational services and supports for families can reduce out-of-home placements for children and facilitate family reunification.
- Co-location with other community services and supports can reduce stigma and improve access, facilitate community collaboration and provide an integrated service experience for clients and their families. These approaches will require determining the appropriate share of costs that should be paid from MHSA funds.
- De-centralized facilities can offer services in locations that are more accessible to clients and their families.

Next steps:

- DMH anticipates the release of the proposed capital facilities guidelines for county plans in January 2007, followed by stakeholder feedback through state-wide conference calls.